Pharmacy Programs Application

VPharm, VHAP-Pharmacy, VScript, VScript Expanded, and Healthy Vermonters Programs

This application is for programs that help Vermonters pay for prescription drugs. People who have a disability or are age 65 or older may be eligible for one of these programs depending on income. The Healthy Vermonters program also helps others with moderate incomes. ***VHAP-Pharmacy, VScript*** and ***VScript Expanded*** are for people who do not get Medicare. ***VPharm*** is for people who do get Medicare. **Please answer each question below for the people applying for coverage.**

Program	VHAP-Pharmacy/VPharm-1	VScript/VPharm-2	VScript Expanded/VPharm-3	Healthy Vermonters
Maximum income*	$ 1,269 per month	$ 1,481 per month	$ 1,904 per month	$ 3,384 per month
WITHOUT Medicare you receive	Prescription drugs	Long-term prescription drugs and discount on short-term prescription drugs		Discount on prescription drugs
WITH Medicare you receive	Prescription drugs not covered by Medicare	Long-term prescription drugs and a discount on short-term prescription drugs not covered by Medicare		Discount on prescription drugs not covered by Medicare
You pay per person	$15 per month	$20 per month	$42 per month	Discounted price for each prescription

* Maximum income shown is for one-person household. Maximum income increases with each additional household member.

Name _____ Social security no. _____
Last First Middle initial

Mailing address _____
Number Street PO Box or RD City or Town State Zip code

Marital status ☐ SIngle ☐ Married ☐ Civil union ☐ Separated ☐ Divorced ☐ Widowed Sex ☐ M ☐ F

Spouse or CU partner _____ Social security no. _____
Last First Middle initial

Is this person also applying? ☐ Yes ☐ No

Are any of your children or stepchildren who are under age 21 living with you? ☐ Yes - ages of children _____ ☐ No

QUESTIONS	APPLICANT	SPOUSE OR CIVIL UNION PARTNER
1. What is your date of birth?		
2. Are you a U.S. citizen? If no, include proof of legal residence.	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you receive Medicare?	☐ Yes ☐ No	☐ Yes ☐ No
3a. Medicare claim number		
3b. Part A (hospital coverage)	Begin date Premium	Begin date Premium
3c. Part B (medical coverage)	Begin date Premium	Begin date Premium
3d. Part C (managed care)	Begin date Premium	Begin date Premium
3e. Part D (drug coverage)	Begin date Premium	Begin date Premium
4. Have you chosen a Part D Prescription Drug Plan?	☐ Yes ☐ No	☐ Yes ☐ No
4a. Plan name		
4b. Contract ID #		
4c. Plan ID #		
4d. Plan start date		
5. Have you applied for "extra help" for Part D through Social Security?	☐ Yes, granted ☐ Yes, denied ☐ No	☐ Yes, granted ☐ Yes, denied ☐ No
5a. If granted, begin date		
5b. If denied, what reason did Social Security give you?	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:
6. If you did not apply, what was your reason?	☐ Over income ☐ Over resource ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Other; explain:

Please complete the other side and sign this application ☛

QUESTIONS	APPLICANT	SPOUSE OR CIVIL UNION PARTNER
7. Do you have private insurance that covers prescription drugs? **(Do not include discount programs)**	☐ Yes ☐ No	☐ Yes ☐ No
7a. Name of insurance company		
7b. Address		
7c. Policy number		
7d. Does this drug coverage have an annual limit?	☐ Yes ☐ No	☐ Yes ☐ No

Please list all current gross income (before taxes, Medicare, and other deductions) for yourself and your spouse or civil union partner, if he or she lives with you. Please answer all questions.

TYPE OF INCOME	APPLICANT AMOUNT (before deductions)	APPLICANT HOW OFTEN? (Mo./Yr.)	SPOUSE OR CIVIL UNION PARTNER AMOUNT (before deductions)	SPOUSE OR CIVIL UNION PARTNER HOW OFTEN? (Mo./Yr.)
Social security retirement	$	per ☐ None	$	per ☐ None
Social security disability	$	per ☐ None	$	per ☐ None
SSI	$	per ☐ None	$	per ☐ None
Railroad retirement	$	per ☐ None	$	per ☐ None
Veteran's benefits	$	per ☐ None	$	per ☐ None
Pensions or annuities	$	per ☐ None	$	per ☐ None
Interest or dividends	$	per ☐ None	$	per ☐ None
Self-employment, including rental	$	per ☐ None	$	per ☐ None
(If yes, please send copy of most recent federal income tax return including all schedules.)				
Wages in last 30 days	$	☐ None	$	☐ None
	Employer / Hrs. per wk. / Hourly wage		Employer / Hrs. per wk. / Hourly wage	
Other income in last 30 days	$	☐ None	$	☐ None
(Such as unemployment, worker's compensation, or alimony)				
Please describe _____			_____	
Do you pay for day care for a child or an incapacitated adult?	$	per month ☐ No	$	per month ☐ No
Do you pay child support or alimony?	$	per month ☐ No	$	per month ☐ No

Please read the following rights and responsibilities and sign below:

The information I have provided is correct to the best of my knowledge. I understand this information may be verified. I understand that I must report all changes, such as changes in income, insurance, address, and household size. I understand the information I have given is private and cannot be seen by the public.

I understand that federal regulation requires that I provide my social security number and that it may be used to check my statements with other agencies, such as the Social Security Administration and the Internal Revenue Service, and for quality control reviews. This requirement may be waived for members of a religious organization that objects to furnishing a social security number.

I understand that intentionally making a false or misleading statement, or concealing or withholding facts, may result in paying the Department, in cash, the value of the prescription discounts I received and may subject me to civil or criminal prosecution.

I understand that I have the right to treatment that is fair and does not discriminate. I may not be treated differently because of race, color, national origin, marital status, sex, sexual orientation, age, religion, political beliefs, place of birth, or because of physical, mental, or emotional conditions. If I have a complaint about being treated differently, I may contact the Office for Civil Rights, Health and Human Services, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201. If I believe I have been discriminated against because of a disability, I may contact: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 South Main Street, Waterbury, VT 05671-1201.

I have reviewed the statements above about my rights and responsibilities and I understand them.

Printed name of applicant | Signature of applicant | Date | Telephone number

Signature of person witnessing or helping to fill out this form | Date

After signing this form, please mail it to: Vermont Department of Taxes, 133 State Street, Montpelier, VT 05633-1401

If you have questions or for current income levels, call Health Access Member Services at 1-800-250-8427.
To use telephone service for people with hearing disabilities, call 1-888-834-7898.